ANNUAL NOTICES

EMPLOYEE BENEFITS DIVISION

5530 OVERLAND AVENUE, SUITE 210

SAN DIEGO, CA 92123

MAIL STOP: O-7

Phone: (888) 550-2203

FAX: (858) 694-3938

Rev: 8/31/2016

IMPORTANT NOTICES

Federal laws require that we provide you with certain notices that inform you about your rights regarding eligibility, enrollment and coverage of health care plans. The following sections explain these rules; please read them carefully and keep them where you can find them.

MEDICARE CREDITABLE COVERAGE NOTICE

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about prescription drug coverage. Scroll down to "Important Notice About Your Prescription Drug Coverage and Medicare" on page 12 for details.

AVAILABILITY OF SUMMARY HEALTH INFORMATION

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits (SBC) which summarizes important information about any health coverage option in a standard format, to help you compare across options. You can access a copy of your SBC on the Employee Benefits website on Insite.

SPECIAL ENROLLMENT RIGHTS

Special enrollment events (below) allow you and your eligible dependents to enroll for health coverage outside the Open Enrollment period under certain circumstances if you lose eligibility for other coverage, become eligible for state premium assistance under Medicaid or the Children's Health Insurance Program (CHIP), or acquire newly eligible dependents. This is required under the Health Insurance Portability and Accountability Act (HIPAA).

If you decline enrollment in a company medical plan for you or your dependents (including your spouse/domestic partner) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in a company medical plan without waiting for the next Open Enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 60 days after the loss of other coverage;

- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption; or
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 60 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

In addition, you may enroll in the Group Benefits plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain such coverage. If you request this change, coverage will be effective the first day of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to plan in which you enroll, please refer to the benefit summaries.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her

newborn earlier than 48 hours (or 96 hours as applicable) after delivery. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PHYSICIAN DESIGNATION NOTICE

Certain Kaiser and Anthem plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the applicable plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Department of Human Resources, Benefits Division at 888-550-2203.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Kaiser or Anthem plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Department of Human Resources, Benefits Division at 888-550-2203.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are receiving this notice because you have recently become covered under the Group Benefits plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description online or contact Employee Benefits Division at (888) 550-2203.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse or domestic partner and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse or domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse or domestic partner dies;
- Your spouse or domestic partner's hours of employment are reduced;
- Your spouse or domestic partner's employment ends for any reason other than his or her gross misconduct;
- Your spouse or domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse or domestic partner.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;

- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated or the domestic partnership ends; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours, death of the employee, or the employee becomes entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (**divorce** or **legal separation** of the employee and spouse or domestic partner or a **dependent child's losing eligibility** for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. If notification is not received within that 60-day period, the dependent, spouse or domestic partner will not be entitled to elect continuation coverage. You must provide this notice to Benefits.

If you do not choose continuation coverage within the 60-day election period, your group health coverage will end as of the last day of the month of the qualifying event.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses or domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both) your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation for his spouse or domestic partner and

children can last up to 36 months after the date of the Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse or domestic partner and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse or domestic partner and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse, domestic partner, or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contacts identified below. For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security

Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

POSSIBLE CONTINUED COVERAGE AFTER COBRA ("CAL -COBRA")

California law provides for 18 months of "After-COBRA" coverage for qualified beneficiaries who are entitled to only 18 months of federal COBRA. It applies only for qualified beneficiaries who began their COBRA coverage on or after January 1, 2003, and who exhausted their 18 months of COBRA coverage. The cost for this "After-COBRA" coverage is 110% of the applicable rate under the group plan. Premiums usually must be remitted to the insurer or HMO, not to the employer. If you are eligible for "After-COBRA" coverage, your employer will provide additional details before the end of your federal COBRA continuation period if the health plan you enroll in offers "After-COBRA" coverage.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **1-877-KIDS NOW or www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2016. You should contact your state for further information on eligibility.

Alabama – Medicaid	Website: http://www.myalhipp.com Phone: 1-855-692-5447
Alaska – Medicaid	Website: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx Phone (Outside Anchorage): 1-888-318-8890 Phone (Anchorage): 1-907-269-6599
Arizona – CHIP	Website: https://www.azahcccs.gov Phone (Outside Maricopa County): 1-800-654-8713 Phone (Maricopa County): 1-602-417-4000 Phone (Out-of-State): 1-800-523-0231
Arkansas — CHIP	Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275
California – Medi-Cal	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-916-552-9200 (Medi-Cal eligibility line) Email: HIPP@dhcs.ca.gov (Health Insurance Premium Payment email)

Colorado – Medicaid	Website: http://www.colorado.gov/hcpf Phone: 1-800-221-3943
Florida – Medicaid	Website: http://flmedicaidtplrecovery.com Phone: 1-877-357-3268
Georgia – Medicaid	Website: http://dch.georgia.gov/medicaid (Click Health Insurance Premium Payment (HIPP)) Phone: 1-678-564-1162
Idaho – Medicaid and CHIP	Website: http://healthandwelfare.idaho.gov/FoodCashAssistance/HealthCoverageAssistance/tabid/2882/Default.aspx Phone: 1-877-456-1233
Indiana – Medicaid	Website: http://www.hip.in.gov (Health Indiana Plan for low-income adults 19-64) Phone: 1-877-438-4479 Website: http://www.indianamedicaid.com (All other Medicaid) Phone: 1-800-403-0964
Iowa – Medicaid	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
Kansas – Medicaid	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884 Phone (In-state): 1-785-296-3512
Kentucky – Medicaid	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
Louisiana – Medicaid	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-342-6207
Maine – Medicaid	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY: Maine relay 711
Massachusetts – Medicaid and CHIP	Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120
Minnesota – Medicaid	Website: http://mn.gov.dhs/ma Phone (Outside Twin City area): 1-800-657-3739 Phone (Twin City area): 1-651-431-2670
Missouri – Medicaid	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005
Montana – Medicaid	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
Nebraska – Medicaid	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
Nevada – Medicaid	Website: http://dwss.nv.gov/ Phone: 1-800-992-0900
New Hampshire – Medicaid	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 1-603-271-5218
New Jersey – Medicaid and CHIP	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
New Mexico – Medicaid and CHIP	Medicaid & CHIP Website: http://www.hsd.state.nm.us/mad/index.html Medicaid & CHIP Phone: 1-888-997-2583
New York – Medicaid	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
North Carolina – Medicaid	Website: http://www.ncdhhs.gov/dma/medicaid/hipp.htm Phone: 1-919-855-4100 (Main office) Phone: 1-855-696-2447 (HIPP)
North Dakota – Medicaid	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
Oklahoma – Medicaid	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

Oregon – Medicaid and CHIP	Medicaid & CHIP Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Medicaid & CHIP Phone: 1-800-699-9075
Pennsylvania – Medicaid	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
Rhode Island – Medicaid	Website: http://www.eohhs.ri.gov/ Phone: 1-401-462-5300
South Carolina – Medicaid	Website: http://www.scdhhs.gov Phone: 1-888-549-0820 (Member Information) Phone: 1-803-264-6838/6847 (HIPP line)
South Dakota – Medicaid	Website: http://dss.sd.gov Phone: 1-888-828-0059
Texas – Medicaid	Website: http://www.gethipptexas.com/ Phone: 1-800-440-0493
Utah – Medicaid and CHIP	Medicaid Website: http://health.utah.gov/medicaid CHIP Website: http://health.utah.gov/chip Phone: 1-866-435-7414 (DWS for Premium Payment Assistance) Medicaid Phone: 1-801-538-6155 CHIP Phone: 1-877-543-7669 (1-877-KIDSNOW)
Vermont– Medicaid	Website: http://www.greenmountaincare.org Phone: 1-800-250-8427
Virginia – Medicaid and CHIP	Medicaid & CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid & CHIP Phone: 1-855-242-8282
Washington – Medicaid	Website: http://www.hca.wa.gov/medicaid/premiumpymt/Pages/index.aspx Phone: **1-800-562-3022, ext. 15473**
West Virginia – Medicaid	Website: http://www.wvrecovery.com/hipp.asp Phone: 1-877-598-5820, HMS Third Party Liability
Wisconsin – Medicaid	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
Wyoming – Medicaid	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 1-307-777-7531

To see if any more states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

IMPORTANT NOTICE ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Group Benefits Plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2017. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during the 2017 plan year listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

NOTICE OF CREDITABLE COVERAGE

Please read this notice carefully. It has information about your prescription drug coverage and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare's prescription drug coverage (called Part D) and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by the prescription drug coverage offered by the medical plans listed below, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2017. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

- Kaiser Permanente HMO
- Kaiser Permanente HDHP with an HSA
- Anthem Blue Cross PPO
- Anthem Blue Cross Select HMO

- Anthem Blue Cross California Care/Full Access HMO
- Anthem Blue Cross HDHP with an HSA

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop your group coverage, Medicare will be your only payer. You can re-enroll in the company-sponsored plan during Open Enrollment or if you have a special enrollment event.

You should know that if you waive or leave coverage and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this group coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the *Medicare & You* handbook for the telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice

when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Date:	August 31, 2016
Name of Entity/Sender:	County of San Diego
Contact — Position/Office:	Employee Benefits Division
Address:	5530 Overland Avenue, Suite 210 San Diego, CA 92123
Phone:	(888) 550-2203

HIPAA PRIVACY NOTICE NOTIFICATION

As a reminder, the County of San Diego has adopted a Health Insurance Portability and Accountability Act (HIPAA) Privacy Policy regarding the privacy of employees' personal health information. This notice describes how medical information about you may be used and disclosed.

To obtain a copy of the Privacy Notice, contact the Employee Benefits Division at (888) 550-2203.

HIPAA PRIVACY NOTICE

Notice of Privacy Practices

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by the Company health plans. This information, known as protected health information (PHI), includes almost all individually identifiable health information held by a self-insured plan — whether received in writing, in an electronic medium, or as an oral communication.

- The Health Care Flexible Spending Accounts
- The Health Care Reimbursement Accounts

The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not the Company as an employer — that's the way the HIPAA rules work. Different policies may apply to other the Company programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with the Company

The Plan, the Company Health and Welfare Plan, or its health insurer or HMO, may disclose your health information without your written authorization to the Company for plan administration purposes. The Company may need your health information to administer benefits under the Plan. The Company agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources personnel are the only the Company employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and the Company, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to the Company, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to the Company information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that the Company cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by the Company from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)

Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See "Contact/Complaints" at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health

care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information
If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information
With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also

request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint

Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)

- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on October 1, 2016. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice. The revised privacy notice will be emailed to you or if you don't have email, it will be mailed to your home address upon request.

Contact/Complaints

If you have questions regarding your privacy rights described in this Notice of Privacy Practices, if you are concerned that the Plan has violated your rights under the HIPAA privacy rules, or if you disagree with a decision made about access to or amendment of your health records, please contact the Privacy Officer at the address or phone number listed below. You are also permitted to send written complaints to the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, Room 509F, 200 Independence Avenue SW, Washington, DC 20201. You may submit your complaint by mail, fax or electronically. For more information about filing complaints, see www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Neither the Plan nor the Company will retaliate against you in any way for exercising your right to file a complaint. You may request a paper copy of this notice at any time by contacting the Privacy Officer at the address listed below.

County of San Diego
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